CRIMSON
INTERNAL MEDICINE

NANCY TACTUK, M.D.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patients Full Name

_____

Last First Middle

_____

Street City State Zip

Phone # Home: _____ Business: _____ Cell: _____ Cell Carrier: _____

Email:_____ Would you like to receive appointment reminders by Text? Y or N Email? Y or N

Birthdate: _____ Sex: M F Ethnicity: _____ Marital Status: M S D W Race:_____
Month/day/year

Social Security # _____ Drivers License # _____ Primary Language:_____

Patients Employer: _____ Position Held: _____

Employers Address: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

Name: _____ Relationship: _____ DOB: _____

Employer:_____ Address: _____

Phone # _____ Position Held: _____ S.S. # _____

INSURANCE INFORMATION

Name of Company Subscribers Name Date of Birth Policy #

_____

_____

Medicare: _____ Medicaid: _____

Blue Cross Blue Shield: Contract # _____ Group # _____ Subscribers Name: _____

Referred By:_____ In Case of Emergency Notify:_____Phone:_____

FULL PAYMENT DUE WHEN SERVICE RENDERED UNLESS COVERED BY BLUE CROSS BLUE SHIELD PMD OR SELECTCARE PLAN. THIS PROVISION APPLIES TO ALL PATIENTS UNLESS WAIVED BY THE PHYSICIAN. IN THE EVENT THE ACCOUNT IS NOT PAID IN FULL THE UNDERSIGNED AGREES TO PAY ALL EXPENSES AND COSTS OF COLLECTION, INCLUDING ATTORNEYS'S FEES, WHETHER BY SUIT OR OTHERWISE. THE UNDERSIGNED HEREBY ASSIGNS TO AND AUTHORIZES THE RELEASE AND PAYMENT OF ANY INSURANCE BENEFITS FROM ANY INSURANCE COMPANY OR GOVERNMENT AGENCY DUE ME DIRECTLY CRIMSON INTERNAL MEDICINE, LLC IN AND FURTHER AUTHORIZES CRIMSON INTERNAL MEDICINE, LLC TO RELEASE ANY INFORMATION ACQUIRED IN EXAMINATION OR TREATMENT TO ANY INSUROR OR GOVERNMENT AGENCY.

_____ _____

DATE PATIENTS SIGNATURE

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